Illinois Department of Public Health FORM APPR					
	NT OF DEFICIENCIES OF CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUI TIPLE CONSTRUCTION		(X3) DATE SURVEY	
			A. BUILDING:		COMPLETED
		IL6015192	B. WING		06/15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	1 00/10/2010
BROOKE	DALE HOFFMAN EST	3 GULF RIJ	ST GOLF RO		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	N ESTATES,		
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
\$ 000	Initial Comments		S 000		N
	Annual Licensure S	urvey			
	Complaint Investiga	ation 1595400/IL80524-No			
	deficiency Incident Report Inve	estigation to Incident of			
	10/08/2015 /IL8074	0-No deficiency			
S9999	Final Observations		S9999		
	Statement of Licens	sure Violations			
	 c) The written polici limited to, the follow 3) A policy to identify strategies to control nurses and other he 	y, assess, and develop risk of injury to residents and ealth care workers associated			
	movement of a resid	ferring, repositioning, or dent. The policy shall that, at a minimum, includes			
	nurses and other he account the resident resident populations physical environmer handling and moven B) Education of nurs	es in the identification,			
П	assessment, and co residents and nurse: workers during resid C) Evaluation of alte	ntrol of risks of injury to sand other health care		Attachment A	
(evaluation of equipm	ent and the environment.		• • • • • • • • • • • • • • • • • • • •	1.45
(equipment and aids, or movement of all o	extent feasible with existing of manual resident handling r most of a resident's weight, by, life-threatening, or		Statement of Licensure Vio	iations
nois Departe	nent of Public Health	<u></u>			

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public	: Health			TOTALAFROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015192	B. WING		06/15/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	00/13/2010
BROOKDALE HOFFMAN EST		ST GOLF RO		
	HOFFMAI	N ESTATES, I	IL 60194	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBF COMPLETE
S9999 Continued From page 5	age 1	S9999		
F) Development of injury to residents care workers asso transferring, reposeresident. This requirement is Based on observative the facility frequire safe transfer and while transferr. This applies to 3 of R107) reviewed for in the sample of 8 and while transferred.	inal circumstances. If strategies to control risk of and nurses and other health ciated with the lifting, itioning, or movement of a sonot met as evidenced by: Ition, interview and record ailed to follow their policies to the ers of residents while toileting ing from bed to a wheelchair. If 7 residents (R103, R104, resident transfer assistance and 4 residents (R114, R115, the supplemental sample.			
The findings includ	e:			
Order Sheet) R132 Parkinson's Diseas muscle weakness a Physician/Healthca March 16, 2016 sho assistance for toilet hygiene and has dit severely impaired of Progress Note date R132 requires phys transfers and freque The Nurse's Notes R132 was being assistance and need when resident starte				
Assistant) and E13	t 3:40pm E12 (RA - Resident (RA) were assisting R132 to the toilet. The front of			

PRINTED: 07/21/2016 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6015192 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD** HOFFMAN ESTATES, IL 60194 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 R132's pants were visibly wet in the crotch and front area when R132 was wheeled into the bathroom in front of the wall grab bar and instructed to hold onto the grab bar. Without locking the wheels of the wheelchair or applying a gait belt, E12 and E13 proceeded to lift R132 to a standing position by pulling R132 up by the waistband of her pants and then pushed the wheelchair out of the way. Once R132 was in a standing position E12 and E13 alternated pulling R132's pants down while the other was pushing on R132's lower back and buttocks to keep R132 in a standing position. R132 would yell out "Don't grab me there! Who told you to do this?" while trying to sit back down. On June 14, 2016 at 12:55pm E2 DON (Director of Nursing) stated R132 should have a gait belt used during resident transfers. 2) According to the June 2016 POS and the Hospice Care Plan R107 had diagnoses including difficulty walking, history of hip fracture, dementia with behavior, muscle weakness, cerebrovascular disease and hypertension. The Personal Service Plan dated March 16, 2016 shows R107 requires physical assistance related to the inability to stand independently during dressing or grooming tasks; needs one person assist with transfers from the wheelchair to the toilet and back; and R107 is unable to stand unassisted. The resident Monthly Summary shows R107 was totally dependent on staff for transfers between surfaces and used a wheelchair. On June 14, 2016 at 10:00am R107 was noted to have a right leg contracture. E14 RA said R107's

right leg was contracted and R107 was unable to bear weight on it. E14 assisted R107 from the bed to a wheelchair by doing a pivot stand while

_	Illinois Department of Public	Health			PORIM APPROVEL
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	:	IL6015192	B. WING		06/45/0040
	NAME OF PROVIDER OR SUPPLIER	STREET AC	IDBESS CITY S	TATE, ZIP CODE	06/15/2016
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	BROOKDALE HOFFMAN EST		N ESTATES, I		
	PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
	S9999 Continued From pa	age 3	S9999		
	the facility told her during a resident tr wheelchair or back have and use gait to not to use a gait be. The hospice Team shows R107 had fato two person assis was found in the canon-use of a gait be.	Care Plan dated May 27, 2016 all precautions and needed one stance with transfers. Nothing are plan regarding the use or elt.			
	sit-to-stand mechar incontinence care to E8 placed R103's h	stant) and E8 (RA) used a nical lift to assist in providing o R103 in her room. E7 and lands on the mechanical lift			
	armpits. The sling fastened around the did not fasten the did wheelchair. While I mechanical lift device R103's incontinence care.	ng behind R103 and under her had a fastening device to be resident's waist. E7 and E8 evice before raising her off the R103 was suspended from the ce, E7 and E8 removed brief and provided E8 said R103 is unable to She cannot transfer without nical lift."			
	1-30, 2016 shows R depression, history	tian order sheet) dated June 103's diagnoses include of aspiration pneumonia, and s an order for a "sit and stand eptember 23, 2015.			
	2016 shows: R103 related to the inabilit during dressing or g	rvice Plan dated March 1, requires physical assistance y to stand independently rooming tasks. R103 is owel and bladder; needs			

	repartment of Public	Health			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		IL6015192	B. WING		06/15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/15/2016
BROOKI	DALE HOFFMAN EST	04001000	T GOLF RO		
		HOFFMAI	N ESTATES,	IL 60194	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S9999	Continued From pa	ge 4	S9999		
	assist with incontine hygiene.	ence to maintain personal			
	2016 shows R103 is mobility, transfers, of	nly Summary dated May 17, s totally dependent for bed dressing, toilet use, bathing tinent of bladder and bowel.	9 9		
	provided incontinentelled R104 from the waistband of her toilet while R104 her bathroom. After prosaid R104 is totally of the said R104 is tot	16 at 1:25 PM, E9 (RA) ce care to R104 in her room. the wheelchair by grabbing r pants and pivoted her to the ld the grab bar in the oviding incontinence care. E9 dependent on staff to dress, sfer herself for the past 3 or 4			I N
	R104's POS dated a multiple diagnoses i stenosis and demen disturbance.	lune 1-30, 2016 shows ncluding lumbar spinal tia with behavioral			
	2016 shows R104 is dressing, toilet use,	ident Summary dated June 5, totally dependent on staff for bathing and is always and frequently incontinent			ı
)) ()	E10 (RA) provided in her room. E9 and E waistband of her par the wheelchair to the brief was removed a provided by E10. E9 herself, toilet herself all transfers.	ats and transferred her from toilet. The incontinence and perineal care was a said R114 is unable to dress and requires two people for			
	THE MORTHLY RESIDER	nt Summary dated April 11,			

Illinois L	epartment of Public	<u>Health</u>			. 0
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
<u> </u>		IL6015192	B. WING		06/15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1 00/13/2010
BROOK	DALE HOFFMAN EST		ST GOLF ROA		
100000			N ESTATES, II	L 60194	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S9999	Continued From pa	ge 5	S9999		
	2016 shows R114 hand is totally dependressing, toilet use	nas a diagnosis of dementia dent on staff for transferring, and bathing.			
	R114's Personal Se	ervice Plan dated March 21,			
	2016 shows R114 r related to the inabili during dressing or o	equires physical assistance ity to stand independently grooming tasks, and if bowel and bladder.			
	E9 (RA) provided in and E10 lifted R115 and transferred her bed. E10 said R115	16 at 11:17 AM, E10 (RA) and continence care to R115. E9 by the waistband of her pants from the wheelchair to her is unable to dress or toilet the assistance of two staffers.			
	multiple diagnoses f R115's Personal Se requires physical as	June 1-30, 2016 shows for R115 including dementia. rvice Plan shows R115 sistance related to the ependently during bathroom nent of bladder.			
	2016 shows R115 is bed mobility, transfe	ident Summary dated May 9, totally dependent on staff for erring, dressing, toilet use and tof bowel and bladder.			
	provided incontinent was laying in bed. A incontinence care, ER116 from the bed to the waistband of her bed to the wheelchai	16 at 10:30 AM, E10 and E11 ce care to R116 while she after completing the E10 and E11 transferred to the wheelchair by holding pants and lifting her from the ir. E10 said R116 is unable e assistance of two people.			

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IL6015192	B. WING		06/15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
BROOKI	DALE HOFFMAN EST	a GULF KI)	ST GOLF ROANN ESTATES, I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLI
S9999	2016 shows R116 r bed to wheelchair a R116's Monthly Res 13, 2016 shows R1 dementia and is tot mobility, transfers, o	ervice Plan dated March 21, needs 2-person transfer from	S9999		
	Belts policy dated E Transfer Belt should of the resident and during the transfer.' One-Person Transfe Two-Person Transfe 2007 include: "Place	er a Resident-Gait/Walking December 2007 includes: "A d be used to ensure the safety the associate who is assisting 'The facility's Complete a er and Complete a er policies dated December the belt around the I fit it snugly but comfortably		5	
	fastening at the cen both sides from und Using a back and fo	ter frontGrasp the belt on lerneath or side handles. orth rocking motion, pull to of three. Use your knees and			
	for a vaccination aga resident, in accorda recommendations o	nually administer or arrange ainst influenza to each			
,	Disease Control and recent to the time of vaccination is medic resident has refused vaccinations for all re	I Prevention that are most vaccination, unless the ally contraindicated or the I the vaccine. Influenza esidents age 65 and over by November 30 of each year			

PD7N11

	epartment of Public	Health				
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE 5 COMPL	
		IL6015192	B, WING		DEM	5/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				TATE, ZIP CODE	00/13	0/2016
BROOKE	DALE HOFFMAN EST	S GOLF RD 2150 WE	ST GOLF ROA	AD		
			N ESTATES, I	L 60194		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	not available before admitted after Nove season, and until Fe appropriate, receive to or upon admission vaccine supplies are the admission, unle contraindicated or the vaccine. (Section 2-b) A facility shall documedical record that influenza was admir contraindicated. (Sec.) A facility shall proadministration of a peach resident in accrecommendations or	cument in the resident's an annual vaccination against histered, refused or medically action 2-213 of the Act) vide or arrange for annumococcal vaccination to				
	Disease Control and received this immun	I Prevention, who has not ization prior to or upon ility unless the resident				
	refuses the offer for vaccination is medic 2-213 of the Act)	vaccination or the ally contraindicated. (Section				
	medical record that a pneumococcal pneu administered, refuse contraindicated. (See	ument in each resident's a vaccination against monia was offered and d, or medically ction 2-213 of the Act) not met as evidenced by:				
•	failed to provide influ	and record review the facility enza and pneumococcal sidents in the facility.				
-	This applies to 5 of 6 R104, R105 and R10 immunizations in the	residents (R102, R103, 97) reviewed for sample of 8.				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD** HOFFMAN ESTATES, IL 60194 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) \$9999 | Continued From page 8 S9999 The findings include: 1) R102 was admitted to the facility on January 13, 2014. No documentation regarding administration of the influenza vaccine for the 2015 Flu season was found in the resident's medical record. No documentation regarding the administration date of the pneumococcal vaccine or if the vaccine was offered to R102. 2) R103 was admitted to the facility on January 3, 2013. E2 DON stated R103 was on hospice in October 2015 when an outside provider came to administer the flu shots so it was not offered to R103. No documentation regarding the administration date of the pneumococcal vaccine or if the vaccine was offered to R103. 3) R104 was admitted to the facility on October 23, 2015. No documentation regarding administration of the influenza vaccine for the 2015 Flu season was found in the resident's medical record. 4) R105 was admitted to the facility on January 23, 2016. No documentation regarding administration of the influenza vaccine for the 2015 Flu season was found in the resident's medical record. No documentation regarding the administration date of the pneumococcal vaccine or if the vaccine was offered to R105. 5) R107 was admitted to the facility on June 26, 2014. E2 DON stated R107 was on hospice in October 2015 when an outside provider came to administer the flu shots so it was not offered to R107. No documentation regarding the administration date of the pneumococcal vaccine or if the vaccine was offered to R107. On June 14, 2016 at 4:33pm E2 DON stated R107's

<u> Illinois D</u>	epartment of Public	Health			FORMAPPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IL6015192	B. WING		06/45/2046
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	06/15/2016
BROOKE	DALE HOFFMAN EST	S GOLF RD 2150 W	EST GOLF RO	AD	
			AN ESTATES,	IL 60194	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
S9999	Continued From pa	ge 9	\$9999		
	condition had impro hospice on June 13	oved and was taken off of s, 2016.			
	On June 14, 2016 E Services) stated the pneumococcal vaco	E15 (District Director of Clinic e facility doesn't offer the cine.	al		
	outside company co	at 4:33pm E2 DON stated an omes in only one time per yea vaccines and it was in Octoberason.	ar er		
	1, 2008 includes: "T or assist residents influenza vaccine. F provided or assistar the vaccine. Family	es-Influenza policy dated Apr he community should provide n obtaining an annual neumovax should also be nee provided toward receiving members are permitted to	g .		
	the vaccination and appropriate docume The National Hospic Organization websi hospice patients are degree, they may st the vaccination and that they would benefit of the properties of the vaccination and that they would be the properties of the vaccination and that they would be the properties of the vaccination and that they would be the properties of the vaccination and the vaccina		9		
	website shows "Vac is especially importa severe flu illness." T persons including re other long-term care		C 1		
	Policies - No resider evaluation to be in n admitted to or kept in Neither shall any suc	Admission and Discharge nt determined by professional eed of nursing care shall be n a sheltered care facility. ch resident be kept in a ted and classified for			

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6015192 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD BROOKDALE HOFFMAN ESTS GOLF RD **HOFFMAN ESTATES, IL 60194** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 10 \$9999 This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow their policy for admission/discharge criteria and residency agreement by continuing to house residents in the sheltered care area who had been assessed by the facility to require a higher level of nursing care. This applies to 3 of 7 residents (R103, R104, R107) reviewed for ADLs (activities of daily living) in the sample of 8 and 5 residents (R114-R117, R132) in the supplemental sample. The findings include: 1). On June 13, 2016 at 1:45 PM, E7 (RA-Resident Assistant) and E8 (RA) used a sit-to-stand mechanical lift to assist in providing incontinence care to R103 in her room. E7 and E8 placed R103's hands on the mechanical lift device and put a sling behind R103 and raised her off the wheelchair. While R103 was suspended from the mechanical lift device. E7 and E8 removed R103's incontinence brief and provided perineal care using disposable wipes. E8 said "R103 requires total care. She is unable to stand on her own. She cannot dress herself, cannot use the toilet by herself, or transfer without the use of a mechanical lift. It's almost been a year that R103 has needed the mechanical lift for transfers." R103's POS (physician order sheet) dated June 1-30, 2016 shows R103's diagnoses include depression, history of aspiration pneumonia, and dementia and shows an order for a "sit and stand equipment" dated September 23, 2015.

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD BROOKDALE HOFFMAN ESTS GOLF RD **HOFFMAN ESTATES, IL 60194** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 11 S9999 R103's Personal Service Plan dated March 1, 2016 shows: R103 requires physical assistance related to the inability to stand independently during dressing or grooming tasks. R103 needs total assist with dressing and grooming. R103 is incontinent of both bowel and bladder; needs assist with incontinence to maintain personal hygiene. Requires physical assist on evacuation and drills. The Resident Monthly Summary dated May 17. 2016 shows R103 is totally dependent for bed mobility, transfers, dressing, toilet use, bathing and is always incontinent of bladder and bowel. 2). On June 13, 2016 at 1:25 PM, E9 (RA) provided incontinence care to R104 in her room. E9 lifted R104 from the wheelchair and pivoted her to the toilet while R104 held the grab bar in the bathroom. E9 removed R104's incontinence brief and stated the brief was wet with urine. E9 handed toilet paper to R104. E9 reminded R104 to use the toilet paper to clean herself. R104 dabbed her shoes with the toilet paper, but at no time did she use the toilet paper appropriately. E9 wiped R104's perineal area with disposable wipes, placed a new incontinence brief and pants on R104 and lifted her off the toilet and placed her on the wheelchair. E9 said R104 is totally dependent on staff to dress, toilet herself, or transfer herself for the past 3 or 4 months. R104's POS dated June 1-30, 2016 shows multiple diagnoses including lumbar spinal stenosis and dementia with behavioral disturbance. Nursing documentation dated April 16, 2016

Illinois C	epartment of Public	Health			FORM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING;	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IL6015192	B. WING		06/15/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
BROOK	DALE HOFFMAN EST		ST GOLF ROAN ESTATES, I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
S9999	Continued From pa	ge 12	S9999		
	hallways for a long Resident now just h wants to sit down, re	Resident would walk in the time as her baseline. selping with transfers then equiring a wheelchair."			
	shows "Assessmen and physically."	t: Significant decline mentally			
	2016 shows R104 is	ervice Plan dated March 1, s incontinent of bladder and st with evacuation and drills.			
	2016 shows R104 is dressing, toilet use,	sident Summary dated June 5, is totally dependent on staff for bathing and is always er and frequently incontinent			
	eating lunch in the d spoon in her hand a on her plate. R114 a mouth with the spoo to get any food from	16 at 12:15 PM, R114 was lining room. R114 had a nd attempted to eat the food used a motion of plate to in, however, R114 was unable the plate to her mouth. After 114 was assisted by staff to			
	(RA) provided incont room. E9 and E10 li of her pants and trar wheelchair to the toil was removed and pe E10. E9 said R114 i	tinence care to R114 in her ifted R114 by the waistband asferred her from the let. The incontinence brief erineal care was provided by s unable to dress herself, uires two people for all			
1	On June 14, 2016 at fed lunch by E9 after	12:45 PM, R114 was being R114 unsuccessfully			

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD BROOKDALE HOFFMAN ESTS GOLF RD **HOFFMAN ESTATES, IL 60194** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 13 S9999 attempted to feed herself. The Monthly Resident Summary dated April 11, 2016 shows R114 has a diagnosis of dementia and is totally dependent on staff for transferring, dressing, toilet use and bathing. R114's Personal Service Plan dated March 21. 2016 shows R114 requires physical assistance related to the inability to stand independently during dressing or grooming tasks, incontinence care of bowel and bladder and requires physical assist for evacuation and drills; and uses a wheelchair. 4). On June 13, 2016 at 12:05 PM, R115 was being fed lunch by E9 in the dining room. On June 14, 2016 at 12:30 PM, R115 was being fed lunch by her family member. On June 14, 2016 at 11:17 AM, E10 (RA) and E9 (RA) provided incontinence care to R115. E9 and E10 lifted R115 by the waist of her pants and transferred her from the wheelchair to her bed. E10 said R115 is unable to dress or toilet herself and requires the assistance of two staff members for transfers. R115's POS dated June 1-30, 2016 shows multiple diagnoses for R115 including dementia. R115's Personal Service Plan shows R115 eats pureed foods and requires assistance by staff, requires physical assistance related to the inability to stand independently during bathroom tasks, is incontinent of bladder and requires physical assist for evacuation and drills. R115's Monthly Resident Summary dated May 9,

2016 shows R115 is totally dependent on staff for

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD** HOFFMAN ESTATES, IL 60194 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 14 S9999 bed mobility, transferring, dressing, toilet use and is always incontinent of bowel and bladder. 5). On June 14, 2016 at 10:30 AM, E10 (RA) and E11 (LPN-Licensed Practical Nurse) provided incontinence care to R116 while she was laying in bed. E10 said R116 had a large bowel movement while outside for activities and required incontinence care. E10 and E11 provided incontinence care as well as placing clean pants on R116 without any assistance by the resident. E10 and E11 transferred R116 from the bed to the wheelchair by holding the waistband of her pants and lifting her from the bed to the wheelchair. E10 said R116 is unable to dress herself, toilet herself or transfer without the assistance of two people. R116's Personal Service Plan dated March 21, 2016 shows R116 needs total assist with dressing and grooming, requires physical assistance related to the inability to stand independently during bathroom tasks, is incontinent of both bladder and bowel, needs physical assist for evacuation and drills, and needs 2-person transfer from bed to wheelchair and toilet. R116's Monthly Resident Summary dated April 13, 2016 shows R116 has a diagnosis of dementia and is totally dependent on staff for bed mobility, transfers, dressing, toilet use, bathing and is frequently incontinent of bladder and bowel. 6). On June 14, 2016 at 1:00 PM, E8 (RA) and E9 (RA) transferred R117 from the wheelchair to the toilet by holding the waistband of his pants. E8 placed a new incontinence brief on R117. E9 said R117 requires the assistance of two people

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to transfer and is unable to dress or toilet himself.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6015192 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD HOFFMAN ESTATES, IL 60194** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 15 S9999 R117's Personal Service Plan dated March 14. 2016 shows R117 is incontinent of bladder and bowel and requires physical assist with evacuation drills. 7) According to the June 2016 POS (Physician Order Sheet) R132 has diagnoses including Parkinson's Disease, dementia with behavior, muscle weakness and gait abnormalities. The Physician/Healthcare Provider Plan of Care dated March 16, 2016 shows R132 needs extensive assistance for toileting, transferring, bathing, and personal hygiene and has difficulty following cues with severely impaired cognition. It also shows R132 needs extensive assistance with evacuation in case of an emergency. A Physical Therapy Progress Note dated March 15, 2016 shows R132 requires physical assist to accomplish transfers and frequently needs extensive instruction. The Nurse's Notes show R132 needed assistance with activities of daily living and transfers from 3 caregivers on May 9, 2016, May 16. 2016 and June 2, 2016. . On June 13, 2016 at 3:40pm E12 RA (Resident Assistant) and E13 RA were assisting R132 from the wheelchair to the toilet. The front of R132's pants were visibly wet in the crotch and front area. E12 and E13 proceeded to lift R132 to a standing position. Once R132 was in a standing position E12 and E13 alternated pulling R132's pants down while the other was pushing on R132's lower back and buttocks to keep R132 in a standing position. R132 would yell out while trying to sit back down. On June 14, 2016 at 12:55pm E2 DON (Director of Nursing) stated R132 usually needs two

person assistance and needed a gait belt used

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD HOFFMAN ESTATES, IL 60194** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 16 S9999 during resident transfers. 8) According to the June 2016 POS and the Hospice Care Plan R107 had diagnoses including difficulty walking, history of hip fracture, dementia with behavior, muscle weakness, cerebrovascular disease and hypertension. The Personal Service Plan dated March 16, 2016 shows R107 requires physical assistance related to the inability to stand independently during dressing or grooming tasks; needs one person assist with transfers from the wheelchair to the toilet and back; and R107 is unable to stand unassisted. The resident Monthly Summary shows R107 was totally dependent on staff for transfers between surfaces, bed mobility, dressing, toilet use, bathing, used a wheelchair, and was always incontinent of bowel and bladder. On June 14, 2016 at 10:00am R107 was noted to have a right leg contracture. E14 RA said R107's right leg was contracted and R107 was unable to bear weight on it. E14 assisted R107 getting dressed. R107 did not provide much assistance with her own care in dressing. The facility's Residency Agreement revised June 15, 2015 shows "Under no circumstances may Community accept or retain a person for residency if the person: ...3. Requires total assistance with two (2) or more activities of daily living. Total assistance means staff or another individual performs the entire activity of daily living without participation by the resident. 4. Requires the assistance of more than one paid caregiver at any given time with an activity of daily living. 5. Requires more than minimal assistance in moving to a safe area in an emergency, unless assistance is provided at all times by a private

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caregiver."

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD HOFFMAN ESTATES, IL 60194** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 17 S9999 The facility's policy entitled Admission/Discharge Criteria Policy IL-3 effective June 1, 2010 shows: "Admission Criteria: ...g) Demonstrates ability to bear full weight during transfers which may include assistance of walker or cane or other approved assistive devices. Discharge Criteria: ...g) If the community determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the community which may include any of the following: 1). Incontinence where the resident cannot or will not participate in management of the problem. 2). Immobility where the resident requires total assistance in exiting the building. 3). Any ongoing condition requiring a two-person transfer and/or mechanical lift device." Section 330,790 Infection Control a) Policies and procedures for investigating. controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 III. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 III. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. This requirement is not met as evidenced by: Based on observation and record review the facility failed to provide hand washing after incontinence care and during medication pass. This applies to 1 of 7 residents (R105) reviewed for infection control and 3 residents (R132, R133 and R134) in the supplemental sample.

The findings include:

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6015192 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD HOFFMAN ESTATES, IL 60194** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 18 S9999 1) On June 13, 2016 between 3:20pm and 3:35pm during medication pass, E16 LPN (Licensed Practical Nurse) did not wash her hands or use hand sanitizer before or after administering medications to R133 and R134 without first washing hands or using hand sanitizer. After administering oral medications to R133 and R134, E16 donned gloves and administered Combigan eye drops, one drop to each eye, to R105, then removed her gloves. 2) The Physician/Healthcare Provider Plan of Care dated March 16, 2016 shows R132 needs extensive assistance for toileting, transferring and personal hygiene. On June 13, 2016 at 3:40pm the front of R132's pants were visibly wet in the crotch and front area. E12 RA (Resident Assistant) and E13 RA donned gloves and assisted R132 to the toilet, removed R132's soiled pants and incontinence brief and cleaned R132's legs. Without changing gloves they performed incontinence care for R132, placed a new incontinence brief and clean pants on and assisted R132 back into the wheelchair. With the same gloves, they held the hand bars of the wheelchair, placed the wheelchair in front of the sink, locked the wheels of the wheelchair and turned on and off the water by grasping the handles of the sink. The facility's Hand Washing policy dated June 2014 includes: "A minimum twenty second hand washing should be performed in situations including but not limited to: Before preparing or handling medications. After offering incontinence care/Foley care. After contact with blood, urine, feces, oral secretions, mucous membranes, or broken skin. After handling items potentially

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD** HOFFMAN ESTATES, IL 60194 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE **TAG** DATE DEFICIENCY) S9999 Continued From page 19 \$9999 contaminated with any resident's glood, excretions, or secretions," Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 330.Appendix E. In addition, an unnecessary drug is any drug 1) in an excessive dose, including in duplicative therapy: 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to document behavior monitoring and non-pharmacological interventions for residents taking psychotropic medications. This applies to 2 of 3 residents (R103, R104) reviewed for psychotropic medications in the sample of 8 and 1 resident (R115) in the supplemental sample. The findings include: 1). On June 13, 2016 at 1:45 PM, E7 (RA-Resident Assistant) and E8 (RA) used a sit-to-stand mechanical lift to assist in providing incontinence care to R103 in her room. R103 was non-verbal and did not participate in any of her care. E8 said "R103 requires total care. She is unable to stand on her own. She cannot dress

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY		
AND I DA	TOI CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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	herself, cannot use	the toilet by herself, or use of a mechanical lift."			
	AM, R103 was obse	between 8:15 AM and 11:30 erved in her wheelchair during . R103 appeared to have a of speak.			
	1-30, 2016 shows F depression, history dementia and show equipment" dated S Citalopram HBR (ar	cian order sheet) dated June 2103's diagnoses include of aspiration pneumonia, and s an order for a "sit and stand eptember 23, 2015. httidepressant) 20 mg. norning for depression.			
	2016 shows: "Famil	rvice Plan dated March 1, ly to order medication; nurse onitor for side effects of			
	Psychopharmacolog February 17, 2016 to forms were blank. T documentation to sh were assessed durir	ow depressive symptoms			
	provided incontinend	6 at 1:25 PM, E9 (RA) e care to R104 in her room. ate in the incontinence care, ative.			
1	AM, R104 was obser	vetween 8:15 AM and 11:30 ved in her wheelchair during R104 appeared agreeable			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER		ODRESS CITY S	TATE, ZIP CODE	06/15/2016
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		HOFFMA	N ESTATES,	L 60194	
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	multiple diagnoses stenosis and demed disturbance. The P Alprazolam 0.25 mg R104's Personal Se 2016 shows "Nurse	June 1-30, 2016 shows including lumbar spinal ntia with behavioral POS shows R104 takes g. twice a day for anxiety. ervice Plan dated March 1, to monitor for side effects. ications include the following:			
	Psychopharmacologic February 17, 2016 to forms were blank. documentation to shape were assessed duri	ior Monitoring Records: gic Medications for the period to present were reviewed. All The facility lacked now symptoms of anxiety ng this period or any al interventions were provided			
	E9 (RA) provided in and E10 lifted R115 and transferred her	16 at 11:17 AM, E10 (RA) and continence care to R115. E9 by the waistband of her pants from the wheelchair to her ble to assist with her care and			
	multiple diagnoses fand an order for Tra	une 1-30, 2016 shows or R115 including dementia zadone 25 mg. every evening order was dated December			
	R115's Personal Ser 2016 shows "Nurse monitor side effects	vice Plan dated March 21, to order, administer and of medication."			
	Psychopharmacolog	or Monitoring Records:			

PRINTED: 07/21/2016

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6015192 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD HOFFMAN ESTATES, IL 60194** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 22 S9999 forms were blank. The facility lacked documentation to show symptoms of depression were assessed during this period or any non-pharmacological interventions were provided to R115. The facility lacked a policy to ensure behavior tracking and non-pharmacological interventions were in place for residents taking psychoactive medications. Section 330.3620 General Building Requirements Every existing facility shall: q) Install partitions, screens, shields, or other means to protect residents from thermal hazards such as radiators, hot water or steam pipes, baseboard heaters, therapy equipment, or other surfaces accessible to residents which may exceed a temperature of 140 degrees Fahrenheit. Any protective device shall be designed and installed so that it does not present a fire or safety hazard or adversely affect the safe operation of the equipment. This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an electric towel heater was not accessible to ambulatory residents residing in the secured dementia unit. This applies to 14 of 22 residents (R109, R110, R112, R119-R125, R127, R128, R130, R131) in the supplemental sample residing in the secured dementia unit and identified as being able to ambulate or self-propel in a wheelchair. One June 14, 2016 between 10:30 AM and 11:30 AM, in the secured dementia unit, the daily exercise activity took place outside on the patio. The door from the patio was held open with a

chair and residents who were able, could move freely from the patio to inside the facility without

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6015192 B. WING 06/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2150 WEST GOLF ROAD **BROOKDALE HOFFMAN ESTS GOLF RD HOFFMAN ESTATES, IL 60194** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 | Continued From page 23 S9999 staff assistance. No staff were present in the dining room. At 11:45 AM, E9 (RA) removed hot, damp washcloths from a towel warmer located on the counter in the dining area of the dementia unit. E9 used a tongs to remove the washcloths from the warmer and placed them in a bowl. E9 said she gives the towels to the residents to clean their hands prior to meals and that the towels were too hot for her to touch with her bare hands. E9 explained how she uses the tongs to hold the washcloths by the corner to cool them before handing them to the residents and sometimes runs them under cool water if they are still too hot. E9 said, "I have seen residents go over and open the towel heater and reach in when we aren't looking." The outside of the towel warmer was warm to the touch, the towels removed from the inside were steaming, and the inside surface was hot to the touch. The outside of the towel warmer had an on/off switch. No temperature control feature was present on the towel warmer The towel warmer operation manual shows the inside temperature ranges between 70-80 degrees centigrade (158 and 176 degrees Fahrenheit). The facility identified the following as residents residing in the secured dementia unit who can either ambulate or self-propel in a wheelchair: R109, R110, R112, R119-R125, R127, R128, R130, and R131. On June 15, 2016 at 11:17 AM, E1 (Executive Director) said she was told the towel heater was not meant to be in an area where residents have access to it. The facility lacked a policy for placement of towel heaters in resident areas. Section 330.3970 Hazardous Areas and

Illinois D	Department of Public	Health			FORM APPROVED
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		IL6015192	B. WING		06/15/2016
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BROOK	DALE HOFFMAN EST	S GOLF RD 2150 WES	ST GOLF ROA N ESTATES, IL	AD.	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON OF
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S9999	Continued From pa	ige 24	S9999		
	Combustible Storag Every existing facilit requirements: f) Floor type heaters permitted. (B) This requirement is Based on observation failed to ensure a flo in a resident room. This applies to 1 res supplemental samp The findings include On June 13, 2016 a	ge ty shall meet the following s or furnaces are not not met as evidenced by: ion and interview the facility oor type heater was not in use sident (R118) in the ole reviewed for room safety. e: at 9:45am an electric space g on the floor next to the bed			
	On June 13, 2016 a room gets too cold f	at 4:00pm R118 stated if the for her, she will plug in the would warm the room up.			
	On June 14, 2016 at facility would not allo resident room.	at 5:00pm E2 DON stated the ow a space heater in a			
	On June 15, 2016 at facility did not have a space heaters in res	t 10:00am E2 stated the a policy regarding the use of sident rooms.			
		(B)			